California Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	CA250000210	A. BUILDING: _____ B. WING _____	C 02/19/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD - RIVERSIDE CLINIC	3772 TIBBETS STREET RIVERSIDE, CA 92506

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments The following reflects the findings of the California Department of Public Health during the investigation of one entity reported incident. Entity reported incident number: CA00372043 Representing the Department of Public Health: Surveyor 1729/18918, HFEN The inspection was limited to the specific entity reported incident investigated and does not represent the finding of a full inspection of the facility. A violation of the regulations was identified and a deficiency was written for this entity reported incident.	A 000	We apologized to Patient A on the phone, updated her address in the medical record and reassured her that Planned Parenthood is committed to protecting patient privacy and to conducting an immediate investigation into how the error occurred. A follow up apology letter was mailed to Patient A by the HIPAA Privacy Officer thanking her for contacting us and reassuring her that Planned Parenthood is committed to protecting patient privacy, is conducting a full investigation into the incident, and will do everything possible to prevent an error like this from happening again. The Health Center Manager immediately discussed the incident with Front Office Specialist (FOS) staff and reviewed the policy and procedure for verifying and updating patient demographic information at each and every visit. The Health Center Manager performed a root cause analysis with the Director of Quality Management to determine what contributing factors led to the error. This resulted in an additional step in the patient check out process. The FOS now reviews the patient's check out paperwork to determine if the patient has initialed that all demographic information is correct. If there are no patient initials on the paperwork, the FOS will verbally confirm the accuracy of the patient's demographic information with the patient and will also notify the Health Center Manager.	9-24-13 9-26-13 9-26-13 9-26-13
A 001	Informed Medical Breach Health and Safety Code Section 1280.15 (b)(2), " A clinic, health facility, agency, or hospice shall also report any unlawful or unauthorized access to, or use or disclosure of, a patient's medical information to the affected patient or the patient's representative at the last known address, no later than five business days after the unlawful or unauthorized access, use, or disclosure has been detected by the clinic, health facility, agency, or hospice." The CDPH verified that the facility informed the affected patient(s) or the patient's representative(s) of the unlawful or unauthorized access, use or disclosure of the patient's medical information.	A 001		

Licensing and Certification Division

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Diane R. DeLisle — TITLE: HIPAA Privacy Officer — (X6) DATE: 3/6/14

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A 017	Continued From page 1	A 017	The Health Center Manager reviewed the incident and the updated patient check out process with all health center staff at their staff meeting. Monitoring of compliance to the policy and procedure for verifying and updating patient demographic information at each and every visit including during the check-out process, has been included in the annual performance evaluation. The Health Center Manager is responsible for conducting the annual performance evaluation. The annual review process is part of our quality assurance program. The Health Center Manager is responsible for continuously monitoring compliance to all HIPAA privacy policies and procedures in their health centers including protection of patient privacy through verification and updating of patient demographic information at the time of patient check out. In addition, the HIPAA Privacy Officer conducts HIPAA training for all new health center staff as part of the agency's orientation and training program as well as an annual HIPAA Compliance Training review. HIPAA compliance audits are also conducted annually at a minimum of six health centers. All corrective actions were completed by 9-27-13.	9-27-13
A 017	1280.15(a) Health & Safety Code 1280 (a) A clinic, health facility, home health agency, or hospice licensed pursuant to Section 1204, 1250, 1725, or 1745 shall prevent unlawful or unauthorized access to, and use or disclosure of, patients' medical information, as defined in subdivision (g) of Section 56.05 of the Civil Code and consistent with Section 130203. The department, after investigation, may assess an administrative penalty for a violation of this section of up to twenty-five thousand dollars ($25,000) per patient whose medical information was unlawfully or without authorization accessed, used, or disclosed, and up to seventeen thousand five hundred dollars ($17,500) per subsequent occurrence of unlawful or unauthorized access, use, or disclosure of that patients' medical information. For purposes of the investigation, the department shall consider the clinic's, health facility's, agency's, or hospice's history of compliance with this section and other related state and federal statutes and regulations, the extent to which the facility detected violations and took preventative action to immediately correct and prevent past violations from recurring, and factors outside its control that restricted the facility's ability to comply with this section. The department shall have full discretion to consider all factors when determining the amount of an administrative penalty pursuant to this section. This Statute is not met as evidenced by: Based on interview and record review, the facility failed to prevent an unauthorized disclosure of Patient A's Protected Health Information (PHI), when a laboratory result was sent to Patient A's	A 017		

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A 017	Continued From page 2 old address. This failed practice resulted in the potential for emotional harm to Patient A. Findings: On February 19, 2014, at 8:50 a.m., a telephonic interview was conducted with the facility's Privacy Officer (PO). The PO stated Patient A reported her laboratory results were sent to her former address and someone in the residence opened the letter and reviewed the results. Patient A stated she had requested an address change, during her visit on September 19, 2013. The PO stated the address was not changed in the system and the laboratory results were sent to the patient's former address, when the patient could not be reached by telephone. The PO stated the letter was addressed to Patient A, but was opened by a resident at the patient's former address. The document included the patient's full name and the test results. A copy of the letter sent to Patient A was reviewed on February 19, 2014. The letter indicated "the incident involved...mailing a letter with your lab results to your attention at your former address. You informed us that a resident at that address opened the letter which was addressed to you...We want to assure you that [the facility]is committed to protecting patient privacy and follow all laws regarding confidentiality and patient privacy."	A 017		